WVU Medicine

WVU Hospitals and University Health Associates
Morgantown, WV 26506

RELEASE OF PROTECTED HEALTH INFORMATION FROM OTHER FACILITIES

F-300 (06/2016)

Note:
For Use Only With Outside facility Records

Patient's Name: _____
First Middle Last

Date of Birth: _____ Social Security #: _____

Date: _____ Date of Service: _____

I Authorize:

_____
Name/Physician Address City, State Phone # Fax#

To Release my Protected Health Information (PHI) to:

Ruby Memorial Hospital/Physicians Office Center Attention:

_____
Medical Center Drive
Morgantown, WV 26506
Phone # 304-598- _____
Fax # 304-598- _____

Dept. or Unit: _____
if not specified, address of HIM Dept.
_____
_____

The specific information to be released includes the following:

____ History and Physical/Office Note ____ Cancer Center ____X-Rays ____ Labs
____ Discharge Summary ____ Physical Therapy ____ Advance Directives
____ Emergency Dept ____ Operative Reports ____ Pathology ____ EKG Tracing

Other _____
Special Instructions _____
The purpose of the release is: _____
Procedure date if applicable: _____
I understand the following:

- **HIV and Mental Health information contained in parts of the records indicated above will be released through this authorization unless otherwise indicated. Do Not Release ☐ Drug/Alcohol ☐ HIV ☐ Mental Health (Psychiatric)**
- **My health record(s) will not be released or obtained unless my signature is on this authorization granting permission.**
- **Only the records checked above will be released for the above-stated reason.**
- **I am entitled to a copy of this completed authorization form.**
- **This authorization valid only for treatment dates the day of or prior to the date of patient's signature.**
- **I understand I have the right to revoke this authorization in writing prior to it being processed.**
- **Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, WVU Healthcare has no responsibility or liability as a result of the re-disclosure, and the HIPAA Privacy Rule would no longer protect such information.**
- **WVU HealthCare cannot require me to sign the Authorization in order to receive treatment.**

_____ _____
SIGNATURE OF PATIENT (14 AND UP) DATE

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE RELATIONSHIP/PROOF DATE

_____ _____
SIGNATURE OF WITNESS DATE